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ABSTRACT

This report provides information for states and school districts on the use of Medicaid to support related services for students with disabilities. The report first presents some background material on the Medicaid program, including information about relevant laws and regulations. The Early and Periodic Screening, Diagnosis and Treatment component and its interface with the Individuals with Disabilities Education Act are also discussed. Procedures for accessing Medicaid reimbursement are briefly considered in an overview of billing practices that schools can follow. The current status of schools' involvement in the Medicaid program is presented, based on data from a recent survey of all states. Survey results are summarized. Additional issues and concerns are discussed, especially as related to the fiscal and eligibility features of the Medicaid program. The report concludes that Medicaid reimbursements for services provided to students with disabilities in schools are a potentially significant resource for districts. Appendices include a list of treatment services federally approved for Medicaid assistance and data on the states' activities in accessing Medicaid for student Individualized Education Program services. (Contains an annotated bibliography of 18 items plus a list of 16 individual and organizational resources.) (DB)

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MEDICAID AS A RESOURCE FOR STUDENTS WITH DISABILITIES

By Eileen M. Ahearn, Ph.D.



Project FORUM

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ABSTRACT

This report was prepared to provide information on resources available to states and school districts on the use of Medicaid to support related services for students with disabilities. The report contains some brief background material on the Medicaid program including information about the laws and regulations. The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component and its interface with the Individuals With Disabilities Education Act is also discussed.

Procedures for accessing Medicaid reimbursement are briefly discussed in an overview of billing practices that schools can follow. The current status of schools' involvement in the Medicaid program is presented including data from a recent survey of all states. The results of that survey are summarized in the narrative and selected portions of the data are included in an appendix.

Issues and concerns gathered from discussions with state personnel and other sources are discussed, especially as they relate to the fiscal and eligibility features of the program. The report concludes that Medicaid reimbursements for services provided to students with disabilities in schools are a potentially significant resource for districts.

The report also contains an annotated list of resources in the form of print references and the identification of individuals and groups with relevant expertise.

MEDICAID AS A RESOURCE FOR STUDENTS WITH DISABILITIES

Introduction

Escalating costs of related services is a critical issue for schools as they search for ways to pay for implementing the components of individualized education programs (IEP) for students with disabilities. In the past few years, changes in the Medicaid policies have made it possible for schools to obtain reimbursement for some services delivered under individualized education plans for students in special education programs. Although many states have begun to use Medicaid benefits for at least some early intervention or preschool special education services, they have not, for the most part, expanded their use of this resource to its full potential for school-age children.

Increasing awareness plus the need to develop new resources to pay for related services for students with disabilities has encouraged states to investigate the use of Medicaid. This report was planned as a result of a number of requests for information received by the National Association of State Directors of Special Education (NASDSE) about procedures for accessing Medicaid benefits for students with disabilities. This brief analysis of Medicaid policy will summarize the Medicaid program particularly as it pertains to students with disabilities, describe billing and reimbursement, discuss the current status of school system access to Medicaid benefits, review the major issues and problems faced by schools in obtaining Medicaid funds, and list some resources that might be of use in facilitating access to those benefits.

Background

Laws and Regulations

Medicaid is a program of federal/state sharing of costs for health and medical services to individuals and families with low incomes and limited assets that was established as Title XIX of the Social Security Act of 1965. Numerous revisions to the law and its regulations have been adopted since that time, most expanding the availability of benefits (many through the addition of eligible recipients) and the types of services covered.

Basically, federal matching funds are available to states to reimburse a portion of the costs of providing ten mandated core services and any of another twenty optional services to those who meet eligibility requirements. States are permitted to expand on the minimum services and eligibility categories within certain boundaries and under some other limiting

conditions set by federal requirements. Each state is assigned a reimbursement percentage ranging from 50% to 83% adjusted annually based on the poverty level of the state. Federal regulations require that the state Medicaid plan include certain mandatory coverage groups such as those receiving Aid to Families with Dependent Children (AFDC). In addition, other criteria such as amount of income and resources or membership in a specially defined group further define eligibility. There is also a requirement for a "certified match" by the state and provisions relative to administrative and direct services.

In 1975, P.L. 94-142, the Education of the Handicapped Act, now known as the Individuals With Disabilities Education Act (IDEA), was passed requiring schools to provide a free, appropriate education including special education and related services to all students found eligible under the Act. In the years immediately after passage of this Act, there were increased recommendations for related services that were traditionally delivered by the medical community such as physical, occupational and speech therapy. Some schools attempted to claim Medicaid funds to cover the costs of those services when they were prescribed as a part of the (IEP) for students with disabilities. In 1982, the Health Care Financing Administration (HCFA), the Medicaid administrative agency, issued a policy declaring that Medicaid funds would not be available for any service included in a child's IEP, since implementing the IEP was the financial responsibility of the school district. However, within a short time this prohibition began to erode as the result of court cases, advocacy actions, and the 1986 amendments to the federal special education law that banned the use of the new funds for infant and toddler services to supplant existing funds from Medicaid and other federal sources.

The Social Security Act was amended in 1988 eliminating the prohibition on the use of Medicaid funds for services included in an Individualized Family Service Plan (IFSP) or an IEP [Section 1903 of the Social Security Act (42 U.S.C. 1396b)]. Actually, many advocates claimed that it was never the intent of Congress that schools be responsible for all related services costs, and they cited as evidence statements in the Senate Report accompanying P.L. 94-142 such as "...the state education agency is responsible for assuring that funds for the education of handicapped children under other federal laws will be utilized..." (Fox and Wicks, 1990, p. 8). The way was then clear for school systems to use Medicaid funds for related services and case management. Accessing those funds usually involves changes in a school's administration, personnel, procedures and expenditures to obtain reimbursement, but the resource can be a significant addition to support the provision of services to students with disabilities.

EPSDT

The Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program was added to the statute in 1967 and implemented through regulations in the early

1970's. EPSDT requires states to include in their Medicaid program periodic, comprehensive medical examinations and prescribed treatments for children beginning at birth and continuing up to the child's twenty-first birthday. Amendments passed in the 1989 Omnibus Budget Reconciliation Act (OBRA) not only raised financial eligibility levels, but also greatly expanded benefits by requiring that states make EPSDT services available whenever a child is suspected of having a condition that requires assessment and further diagnosis and treatment and not only at periodic intervals (Kreb, 1991, p. 1:13). The 1989 amendments also added the condition that states must provide all the services prescribed through EPSDT that are eligible for assistance under federal law including services that are not a part of that state's Medicaid program. (See Appendix A for a list of all services eligible for federal Medicaid assistance.)

Some EPSDT provisions require comprehensive care for children and are, in fact, broader than IDEA. However, as the following comparison shows, the requirements of EPSDT closely parallel requirements under IDEA:

EPSDT	IDEA
▶ identifying and informing eligible children and their parents of the benefits of prevention and of the type of assistance available;	▶ location of all children who might be in need of special education and related services;
▶ assessing a child's health needs through examinations and screenings of physical health and development, vision, dental health and hearing;	▶ a full and individual evaluation of the child's educational needs;
▶ assuring that health problems detected are diagnosed and treated fully and in a timely manner; and,	▶ development of an IEP and placement in an appropriate program
▶ assisting families to use all available health resources (Fox and Wicks, 1990, p. 21-22).	▶ parent training activities relating to a free appropriate education for students with disabilities and assurance that parent(s) participate in the evaluation and team decision processes (IDEA Part B Regulations 34 CFR Part 300).

The correlation between the two statutes and the obligations they impose are clear. Resources available through EPSDT enhance the capacity of schools to meet the other health needs of children that frequently impact on and contribute to their special education needs. The similarity calls out for coordination and cooperation in implementation to promote efficiency in meeting the needs of all eligible children.

Accessing Medicaid Resources

Medicaid Billing and Reimbursement

Before actual billing for Medicaid reimbursement can occur, a state-specific process is necessary to decide on the approach to be used and to put the necessary procedures into place. The complexity of the planning process is suggested in the comment of the individuals involved in designing the procedures for North Carolina quoted in *States Summary: Medicaid Billing Survey*: "We planned for this participation for over 5 years, but we are now billing" (Duncan-Malone, 1993, p. 33). Despite billing and documentation problems cited by a few respondents, some states specified the amount of benefits that have been realized: Illinois started processing in June, 1992 and has returned \$1,075,000 to school districts; Iowa adds approximately \$500,000 to state revenues each year; in Pennsylvania where only 31% of school districts are currently billing, over \$1.5 million was billed to Medicaid in the period from September 1, 1992 to May 1, 1993; and, in South Carolina where 90% of schools are billing, a total of \$7 million in Medicaid benefits has been returned to schools as of July 1, 1993. As reported for Missouri, the billing of Medicaid is "tedious, but achievable" (p. 25).

The limitations of this report preclude a detailed explanation of billing options that can be used to obtain Medicaid benefits. Briefly, there are four main types of billing/reimbursement methods that can be adopted by schools or school districts in billing Medicaid: episode billing, treatment or unit billing, function billing, or a combination model (Mackey-Andrews, 1992, p.3). The episode type involves billing for each specific treatment after it is delivered. Under the unit approach, the provider bills for a specific number of treatments, such as physical or speech therapy, at a predetermined rate after the service has been delivered. More rigorous documentation is required for this type than any other. In the function approach, the cost for specific functions, such as those involved in case management, is determined for a specific period of time and invoices are submitted for individual children based on the provision of the service during a billing period. Maine is currently piloting an administrative case management billing option and also drafting a rehabilitation option for

school districts for its state Medicaid Plan. The combination approach uses one or both of the other two approaches sometimes combined with traditional grant funds to meet the needs of a particular service delivery system.

The burden of recordkeeping and monitoring is often cited as a significant barrier to accessing Medicaid. A provider must be able to demonstrate that services were delivered in accordance with accepted standards. Program monitoring is essential not only for confirmation of compliance with service delivery standards, but also as a prerequisite component of fiscal compliance. federal audit findings of fiscal non-compliance result in a "recoupment" of funds that could be a major catastrophe to any provider agency. It is recommended that a Memorandum of Understanding be negotiated between the Medicaid agency of the state and the school system that sets forth the obligations of each party and provides for both to monitor the provisions regularly (Mackey-Andrews, 1992, p. 2). In some instances, interagency agreements are not only good practice, but a requisite component. Successful collaboration can lead to efficiency in the delivery and monitoring of a program. For example, reviews for compliance can be combined to meet the requirements of both the special education and Medicaid review processes.

Current Status

There is very little published data on the use of Medicaid resources by schools. One reason for the paucity of information is the problematic nature of collecting such data. An illustration can be drawn from the *Survey* by Duncan-Malone and Yeater (1993), the most current summary of school efforts to access Medicaid resources. Survey responses were submitted by each state's Director of Special Education (or designee). The questions in the survey protocol appear to be simple and clear cut but, because they involve states with differing structures, procedures, and laws, the states' responses in some cases can be misleading. For example, in reply to the question, "What percentage of schools in your state do you estimate are currently billing for Medicaid services?" one respondent expressed the concern that any answer would misrepresent the situation in his state where there are various procedures in use: some school districts currently bill Medicaid directly for student services, others have Medicaid providers in their employ who are billing as individual providers, and others bill for administrative case management. In addition, there is extreme variation in the size of that state's school districts—over 500 total school districts with 20 of them representing 90% of the state's student enrollment. Thus, any answer to that survey item could be misleading as to the extent to which schools in the state are actually receiving Medicaid reimbursement and the total number of students whose services are being covered by Medicaid benefits.

Despite the technical problems in gathering accurate information on this topic, the

Survey is an important resource that increases knowledge and awareness of trends in the use of Medicaid for IEP services. A brief analysis of the reported results revealed that only a small portion of the states—22%—have laws requiring schools to bill for Medicaid, although in approximately 75% of the states, at least some schools are currently doing so. For the most part, the reimbursements go to the schools, although in some cases they are shared with the local municipality or the state. Appendix B contains a list of the items in the questionnaire and a table of state responses to some of the items.

Issues and Concerns

The following listing of the major issues that are relevant to school system attempts to access Medicaid benefits was compiled from the references listed in this report and from discussion with state representatives at the 3rd Annual Medicaid \$\$ Reimbursement Conference held in Washington, D.C. in August, 1993.

1) Fiscal issues:

- There can be significant initial costs if a school system establishes traditional billing system because of all the requirements of state and federal Medicaid laws and regulations. However, there are alternatives methods of obtaining reimbursements that access Medicaid benefits for schools using other than conventional billing procedures.
- Maintenance of billing procedures and appropriate financial recordkeeping to conform to audit requirements may pose heavy burdens on schools or school districts.
- The processing of claims sometimes involves an excessive amount of turn-around time delaying receipt of reimbursements.
- In many states there are financial disincentives for school districts to apply for Medicaid benefits. For example, some states (e.g., Connecticut and Massachusetts) require that the reimbursements go to local or state governments, or reduce the district's appropriation by an amount equal to all or part of its Medicaid receipts (e.g. Oregon).
- States and school districts fear there will be a substantial loss of education dollars to support a rapidly growing Medicaid budget.

2) Eligibility issues:

- Changes in family economic conditions often affect eligibility for Medicaid sometimes resulting in inconsistency of student eligibility for benefits.
- Federal regional offices responsible for overseeing the implementation of Medicaid in the states sometimes offer conflicting interpretations of Medicaid regulations concerning what is and is not a reimbursable service between .
- State licensing requirements and job titles in schools often differ from HCFA requirements.
- Provider prerequisites under Medicaid regulations are very restrictive and frequently prevent school services personnel from qualifying.
- State or non-federal resources are required for matching under Medicaid regulations. Therapy paid from federal funds cannot be included in required state matching thereby eliminating all related services provided by staff hired with IDEA funds.

3) Other considerations:

- The federal and state requirements for documentation can consume excessive staff time.
- Federal regional offices are inconsistent in their interpretation of Medicaid regulations.
- Some school personnel are resistant to participating in the Medicaid program.
- Some states have encountered difficulty in getting HCFA to understand and accept the variety of services delivered by schools.
- In some states, amending the state Medicaid Plan to include additional providers such as nurses, psychologists and social workers has been complicated.
- Schools have had problems hiring qualified providers who satisfy Medicaid regulations exactly.

- Interagency collaboration to avoid duplication and excessive costs is a critical component in a successful Medicaid program, but the planning and management of such coordination can be difficult for schools.
- The wide variety of administrative structures in education such as intermediate educational units and cooperative or special school districts may pose unique complications for implementing a Medicaid reimbursement program. However, the use of combined district administrative structures can be an asset in realizing economies of scale for Medicaid-related activities.
- In some locations, the investment necessary to access reimbursement may outweigh the benefits available because of the small number or geographic distribution of Medicaid-eligible children residing in the district.

Conclusion

Widespread interest and activity in accessing Medicaid funds for IEP services by schools is relatively recent. Medicaid benefits are not currently capped, so any service under an IEP that meets EPSDT requirements is eligible for federal reimbursement. Many school districts have ventured into the maze of Medicaid regulations and procedures have devised feasible strategies to meet the fiscal and programmatic requirements of the Medicaid program and increased their financial resources.

There are strong motivations for states and school districts to investigate the benefits available from the Medicaid program. For example, although schools are expected to make an attempt to recover special education costs from an insurance company or other third party payor when possible, there are restrictions to accessing such resources. IDEA prohibits states from imposing financial losses on parents in the provision of a free, appropriate education [20 U.S.C. Chapter 33 §1401(a)(18)], and any negative impact on parents' health insurance benefits is considered a financial loss. Frequently, health plans have limitations on lifetime coverage allowances and any reduction in such benefits is a financial cost. Therefore, in the face of strict limitations on schools' access to other third party payors, Medicaid reimbursements are a valuable, under-used resource.

In states where accessing Medicaid by schools has been established, knowledge has been acquired and procedures have been developed that could be transported to other localities. There is no need for any state or school district to rely solely on its own resources in this matter. The complexity of the Medicaid program makes it imperative that any educational entity embarking on accessing the benefits as well as those who are in the process

of doing so cooperate to share information and procedures. Some states have formed ad hoc sharing groups to improve their strategies in accessing Medicaid for their school systems. One example is the "Medicaid Workgroup" maintained and facilitated by the South Atlantic Regional Resource Center (SARRC).¹ Periodically, SARRC schedules a teleconference to provide its states an opportunity to share updates with each other and to get information from experts in the field on how to access Medicaid benefits to pay for special education related services.

The Medicaid program allows schools to recover some costs and, in the process, to enhance their outreach to poor families and take advantage of the presence of children in the school setting to better meet their health needs. Each state has its own plan for Medicaid and devises its own set of requirements. Much of the apparently complicated groundwork necessary for schools to access Medicaid benefits has already been laid. A considerable amount of assistance is available for districts in many aspects of schools' involvement in the program. An annotated list of resources in the form of printed materials and individual and group expertise that can support access to Medicaid benefits by schools is appended to this report.

¹The Regional Resource Center (RRC) Program, authorized by Public Law 90-247, provides technical assistance to all the States and jurisdictions of the United States through a network of six regional centers. The South Atlantic RRC serves Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, New Mexico, Oklahoma, Puerto Rico, Texas, and the Virgin Islands.

Annotated Resource List

There is tremendous variety between and within states in their use of Medicaid benefits for school-based related services to students with disabilities. State personnel have expressed strong interest in obtaining information about assistance to increase their receipt of Medicaid benefits. The following annotated resource list of documents and individuals or organizations was compiled as an attempt to meet this need. Documents with the most practical and relevant information on the accessing of Medicaid reimbursements by schools are marked with an asterisk (*).

Written Materials

- *Bergman, A. and Walsh, S.(1993). *Medicaid \$\$ reimbursement and national health care reform, 3rd annual conference resource notebook*. Horsham, PA: LRP Publications. {747 Dresher Road, Suite 500, Horsham, PA 19044-0980. Phone: 215-784-0860}

The materials in this notebook provided to participants at the conference include a copy of the *States Summary: Medicaid Billing Survey, Summer 1993* by Duncan-Malone and Yeater, as well as state-specific reports on school access of Medicaid benefits from California, Louisiana, and Baltimore County, MD. The notebook also contains miscellaneous material such as articles, excerpts from laws and regulations, and other related information.

- * Clifford, R., Bernier, K. and Harbin, G. (1993). *Financing Part H services: A state level view*. Chapel Hill, NC: Frank Porter Graham Child Development Center Carolina Policy Studies Program. {University of North Carolina at Chapel Hill, 300 NCNB Plaza, Chapel Hill, N.C. 27514. Phone: 919-962-7374}

This report examines the financing of services to infants and toddlers under Part H of the IDEA and includes the results of a survey of Part H Coordinators from 38 states on the sources used to fund Part H programs and services.

- Clifford, R., Kates, D., Black, T., Eckland, J., and Bernier, K. (1991). *Reconceptualization of financing under P. L. 99-457, Part H*. Chapel Hill, NC: Frank Porter Graham Child Development Center Carolina Policy Studies Program.

Problems in the financing of early intervention services are documented in this short report based on findings from case studies and other data from all the states.

Doherty, D., Kates, D. and Grant, T. (1993). *Resource notebook for collaborative interagency finance workshops*. Washington, D.C.: Child and Adolescent Service System (CASSP), Center for Child Health and Mental Health, Georgetown University Child Development Center. Phone: 202-338-1698

Although this notebook contains only a limited amount of information about schools' use of Medicaid, it does contain a variety of other Medicaid-relevant information including reprints of papers on the conditions and needs of children and families, managed health care, and mental health.

- * Duncan-Malone, L. and Yeater, J. (1993). *States summary: Medicaid billing survey*. Indianapolis, IN: Indiana Department of Education, Division of Special Education. {Room 229, State House, Indianapolis, IN 46204-2897. Phone: 317-232-0570}

This report contains the results of a survey on the status of school access of Medicaid in all 50 states and Puerto Rico. For each state, a contact person is listed in both education and Medicaid. (Much of the contents of this *Summary* are described in the narrative of this report, and selected data from the survey is presented in Appendix B.)

Feder, J., Rowland, D., Holahan, J., Salganicoff, A. and Heslam, D. (1993). *The Medicaid cost explosion: Causes and Consequences*. Baltimore, MD: The Kaiser Commission on the Future of Medicaid.

A detailed presentation of the serious problems of rising costs in the Medicaid Program with a discussion of consequences and policy implications.

- * Fox, H and Wicks, L.N. (1990). *The role of medicaid and EPSDT in financing early intervention and preschool special education services*. Washington, DC: Fox Health Policy Consultants, Inc.

This publication contains detailed background information on the Medicaid program including benefits, services, implementation issues and the efforts in some states to make school districts Medicaid providers. The appendix contains extensive detail from a 50-state survey conducted by telephone interviews with state Medicaid agency staff on Medicaid coverage policies and practices.

Fox, H., Wicks, L., McManus, M. and Kelly, R. (1991). *Medicaid financing for mental health and substance abuse services for children and adolescents*. Technical Assistance Publication Series Number 2, Financing Subseries, Volume 1. Rockville,

MD: U. S. Department of Health and Human Services Public Health Service.

This booklet contains very specific information on the use of Medicaid for mental health and substance abuse services for children and youth. Results of the 50-state survey referenced in the prior publication are also included.

Kastorf, K. (1991). *The Massachusetts experience with Medicaid support of early intervention services*. Chapel Hill, NC: Frank Porter Graham Child Development Center Carolina Policy Studies Program.

This paper, written by the Part H Coordinator for Massachusetts, provides an overview of how one state has successfully integrated use of the Medicaid program in financing Part H services on a statewide basis.

Kreb, R. (1991). *Third party payment for funding special education and related services*. Horsham, PA: LRP Publications.

Although this workbook is currently under revision (new version is due to be published in Fall, 1993), it contains a wide variety of very practical information about establishing a third party reimbursement system (privately or publicly funded) in a public school setting. The chapter headings are indicative of the content: 1) Historical Background - isolates pertinent sections of IDEA and gives comparisons of statute and report language; 2) Issues - a question and answer format of the most important issues in the implementation of a third party system; 3) State Activities and Resources - this material is somewhat dated and will be replaced by more current descriptions in the new edition; 4) "Where To Begin" - suggestions on first steps with information about credentials and billing options among other topics; 5) Health Related Terminology - an explanation of the language, terminology and definitions related to billing and reimbursement, procedure codes and insurance claim forms; 6) Medicaid, EPSDT and Other Federally Funded Third Party Reimbursement Sources - brief description of Medicaid that needs to be updates; 7) Private Insurance and Health Maintenance Organizations - a description and state listing of the major health insurance carriers in the United States; 8) Documentation - a discussion of the types of information and forms required by third party payers and some sample forms; 9) Implementation - a brief checklist of the issues critical for school districts to consider as they implement a third party reimbursement system.

- * Mackey-Andrews, S. (1992, August). Workable approaches and options for billing/reimbursement. Paper presented at the Medicaid \$\$ Reimbursement Conference, Washington, D.C. (See list of consultants below)

This brief paper considers issues in billing and reimbursement under Medicaid, the use of MOUs (Memorandum of Understanding), and the types of billing that can be used by schools to access Medicaid benefits.

- Orloff, T., Rivera, L., Harris, P. and Rosenbaum, S. (1992). *Medicaid and early intervention services: Building comprehensive programs for poor infants and toddlers.* Washington, DC: Children's Defense Fund. {122 C Street NW, Washington, D.C. 20001. Phone: 202-628-8787}

This report contains an excellent summary of the provisions of Medicaid especially as they relate to young children, a review of the basic elements of the Part H program, and a summary of case studies of early intervention programs in LA, MA, ME, NC, ND, OK and WV as of spring, 1991.

- Orloff, T., Rivera, L. and Rosenbaum, S. (1992). *Medicaid reforms for children: An EPSDT chartbook.* Washington, DC: Children's Defense Fund.

This chartbook contains the results of a 50-state survey conducted by the Children's Defense Fund of eligibility, benefits and provider-related changes in the implementation of the EPSDT component of Medicaid.

- Rosenbaum, S. (1993). Medicaid expansions and access to health care. In D. Rowland, J. Feder, & Salganicoff, A. (Eds.), Medicaid financing crisis: Balancing responsibilities, priorities and dollars. Washington, D.C.: AASA Press.

A detailed chapter reviewing the changes in Medicaid from 1984 to 1990 including reforms related to eligibility, providers and benefits and including extensive references and notes.

- Rowland, D., Feder, J., Lyons, B. and Salganicoff, A. (1992). *Medicaid at the crossroads.* Baltimore, MD: The Kaiser Commission on the Future of Medicaid.

A detailed treatment of the role of Medicaid in health insurance today identifying the issues and challenges that the Commission intends to address to improve the Medicaid system.

Scheer, M., Stevens, C., Walker, J. and Smith, M., (1989). *Report on financing health-related early intervention services in Minnesota*. White Bear Lake, MN: Minnesota Curriculum Services Center. {3554 White Bear Avenue, White Bear Lake, MN 55110. Phone: 612-770-3943}

This report details the use of Medicaid resources for the provision of early intervention services in Minnesota, including background information on requirements and a discussion of related issues.

- * U.S. Department of Health and Human Services [Prepared by Lewin/ICF, a division of Health and Sciences International, and Fox Health Policy Consultants] (1991). *Medicaid coverage of health-related services for children receiving special education: An examination of federal policies*. 18 IDELR 558.

This policy clarification issued by HHS and OSERS is a **critically important** resource for anyone interested in the legal requirements surrounding the coverage of health-related services for children receiving special education. It deals specifically with the relationship between Part B of IDEA and Medicaid using a question and answer format to clarify the circumstances under which Medicaid can be billed for services prescribed as a part of a student's IEP.

This publication is available from a number of sources. It is published by the National Technical Information Services (NTIS), U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161. Phone: 703-487-4650. It is also contained in the IDELR (Individuals with Disabilities Education Law Report) published by LRP Publications (see the first entry of this list for contact information).

- * U. S. Department of Health and Human Services, Health Care Financing Administration, Medicaid Bureau (1992). *EPSDT: A guide for educational programs*.

This guide was prepared by HCFA to acquaint schools with the EPSDT program and to illustrate some different types of linkages between schools and the EPSDT program. The appendices contain lists of contact people and agencies related to the Medicaid program at the federal and state levels.

Individuals and Organizational Resources

Beckett, Julie, Child Health Clinics, 239 Hospital School, Iowa City, IA 52242-1011.
Phone: 319-356-4294

Bergman, Allan I., Director, State-Federal Relations, United Cerebral Palsy, Inc., 1522 K Street NW, Suite 1112, Washington, D.C. 20005. Phone: 1-800-USA-5UCP.

Cerpa, Delia, South Atlantic Regional Resource Center, 1236 North University Drive, Plantation, FL 33322. Phone: 305-473-6106.

Children's Defense Fund Health Policy Division, 25 E Street N.W., Washington, D.C. 20001. (Lourdes Rivera) Phone: 202-628-8787

Duncan-Malone, Linda, Ball State University, Muncie, IN. Phone: 317-289-1241.

Fox Health Policy Consultants publish many Medicaid-related resources. They are located at 1140 Connecticut Avenue, NW, Suite 1205, Washington, D.C. 20036. (Harriet Fox and Laurie Wicks) Phone: 202-223-1500.

Friedlander, Ed, Consultant, 220 Sycamore Terrace, Stamford, CT 06902. Phone: 516-248-3113.

Institute for Human Services Management, 7307 MacArthur Boulevard, Suite 205, Bethesda, MD 20816. Phone: 301-229-9455

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Appendix A: List of Treatment Services Federally Approved For Medicaid Assistance

TREATMENT SERVICES FEDERALLY APPROVED FOR MEDICAID ASSISTANCE

- ◆ Vision care including eyeglasses
- ◆ Hearing care including hearing aids
- ◆ Dental care including preventative, restorative and emergency care, medically necessary orthodontics and dental surgery
- ◆ Podiatrist services
- ◆ Optometrist services
- ◆ Chiropractor services
- ◆ Physician services
- ◆ Medical and remedial care recognized under state law and furnished by licensed practitioners practicing within the scope of their practice (i.e., psychologists, social workers, audiologists)
- ◆ Home health services
- ◆ Private duty nursing services
- ◆ Clinic services furnished under physician direction
- ◆ Nursing facility services
- ◆ Inpatient hospital care
- ◆ Outpatient hospital care
- ◆ Personal care services
- ◆ Transportation
- ◆ Case management defined as any services that will assist individuals gain access to needed medical, educational, social, and other services
- ◆ Hospice care
- ◆ Preventive services
- ◆ Federally qualified health center and rural health clinic services
- ◆ Family planning services
- ◆ Laboratory and x-ray services
- ◆ Emergency hospital services
- ◆ Rehabilitation services
- ◆ Intermediate care facilities
- ◆ Intermediate care facility services for the mentally retarded
- ◆ Inpatient psychiatric services
- ◆ Christian Science nurses/sanatoria
- ◆ Physical therapy and related services
- ◆ Occupational therapy
- ◆ Speech and language care for hearing or developmentally related disorders
- ◆ Prescribed drugs, dentures and prostheses
- ◆ Nurse midwife services in states where midwives are legally authorized
- ◆ Respirator care
- ◆ Certified pediatric and family nurse practitioner services in states where practitioners are legally authorized
- ◆ Community supported living arrangements for persons with developmental disabilities
- ◆ Other diagnostic, screening, preventive, and medical or remedial services provided in a facility, a home, or other setting, recommended by a physician or other licensed practitioner of the healing arts, for the maximum reduction of a physical or mental disability

From: *Medicaid Reforms for Children: An EPSDT Chartbook* by Orloff, T., Rivera, L. and Rosenbaum, S., published by the Children's Defense Fund, 1992, p. 58.

Appendix B: Data on States' Activity In Accessing Medicaid for Student IEP Services

*Selected Items from the
Medicaid/Third Party Billing Survey, Spring 1993*

Responses to the following survey items are contained in the Table on the next page of this appendix:

- Does your State have legislation requiring schools to bill for Medicaid?
- What percentage of schools in your state do you estimate are currently billing for Medicaid services?
- What is the level of Medicaid billing activity in your state?

Exploring possibilities/issues	_____
Piloting billing process	_____
School billing	_____
Schools receiving reimbursement	_____
State determination not to bill	_____

- Does the total reimbursement go to the schools or is it shared with the State general fund?

From: Duncan-Malone, L. and Yeater, J. (1993). *States summary: Medicaid billing survey*. Indianapolis, IN: Indiana Department of Education, Division of Special Education. {Room 229, State House, Indianapolis, IN 46204-2897.

DATA ON STATES ACTIVITY IN ACCESSING MEDICAID FOR STUDENT IEP SERVICES

STATE	Billing Required	Percent School Billing	Exploring	Piloting	Billing	Receiving Reimbursement	Reimbursement Recipient
AL	No	4%	No	Yes	Yes	Yes	Schools
AK	No	0%	Yes	No	No	No	Will be shared
AZ	No	0%	Yes	No	No	No	NA
AR	No	43%	No	No	Yes	Yes	Schools
CA	No	NA	No	Yes	No	No	Schools
CO	No	0%	Yes	No	No	No	NA
CT	Yes	4%	Yes	No	Yes	Yes	Municipal Gov't.
DE	Yes	100%	No	No	Yes	Yes	Shared
FL	No	>5%	Yes	Yes	Yes	Yes	Schools
GA	No	NA	Yes	No	No	No	Will go to Schools
HI	No	0%	Yes	No	No	No	NA
ID	No	0%	Yes	No	No	No	Schools
IL	No	25%	No	No	Yes	Yes	Schools
IN	No	>5%	Yes	No	Yes	Yes	Schools
IA	Yes	100%	No	No	Yes	Yes	State Gen'l. Fund
KS	No	50%	No	Yes	Yes	Yes	Schools
KY	No	>5%	Yes	No	No	No	Schools
LA	No	96%	No	No	Yes	Yes	Schools
ME	No	>1%	Yes	No	Yes	Yes	Schools
MD	Yes	30-40%	No	No	Yes	Yes	Schools
MA	No	15-25%	No	Yes	Yes	No	Municipal Fund
MI	Yes	One District	No	Yes	No	No	Shared
MN	No	1%	Yes	Yes	Yes	Yes	Schools
MS	No	0%	Yes	No	No	No	NA
MO	No	NA	No	No	Yes	Yes	Some Share
MT	No	15%	No	No	Yes	Yes	Schools
NE	Yes	2%	No	Yes	Yes	Yes	Schools
NV	No	Unknown	Yes	No	No	No	Undetermined
NH	No	>25%	No	No	Yes	Yes	Schools
NJ	No	0%	Yes	No	No	No	To Be Decided
NM	No	5%	No	Yes	Yes	Yes	Schools
NY	No	30%	Yes	No	Yes	Yes	Shared
NC	No	First Year	No	Yes	Yes	Yes	Schools
ND	No	100%	No	No	Yes	Yes	Schools
OH	No	5%	No	No	Yes	No	Schools
OK	No	One District	No	Yes	Yes	Yes	Schools
OR	No	41%	No	No	Yes	Yes	Shared
PA	No	31%	No	No	Yes	Yes	Schools
RI	Yes	30%	Yes	No	Yes	Yes	Schools
SC	Yes	90%	No	No	Yes	Yes	Schools
SD	Yes	10%	No	No	Yes	Yes	Schools
TN	No	0%	No	No	No	No	NA
TX	No	17%	No	No	Yes	Yes	Schools
UT	No	15-20%	Yes	Yes	Yes	Yes	Schools
VT	No	0%	No	Yes	No	No	Shared
VA	No	20%	No	No	Yes	Yes	Schools
WA	Yes(pending)	21%	No	No	Yes	Yes	Shared(pending)
WV	Yes	100%	No	No	Yes	Yes	Shared
WI	No	10%	No	No	Yes	Yes	Schools
WY	NA	0%	NA	NA	NA	NA	NA

*Derived from the report, *States Summary: Medicaid Billing Survey, Summer, 1993*, by Dundan-Malone & Yeater